General

Guideline Title

Violence and aggression: short-term management in mental health, health and community settings.

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Violence and aggression: short-term management in mental health, health and community settings. London (UK): National Institute for Health and Care Excellence (NICE); 2015 May 29. 64 p. (NICE guideline; no. 10).

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: National Collaborating Centre for Nursing and Supportive Care. Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. London (UK): National Institute for Clinical Excellence (NICE); 2005 Feb. 292 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation) and is defined at the end of the "Major Recommendations" field.

Principles for Managing Violence and Aggression

Improving Service User Experience

Use this guideline in conjunction with NICE's guideline on Service user experience in adult mental health and:

- Work in partnership with service users and their carers
- Adopt approaches to care that respect service users' independence, choice and human rights
- Increase social inclusion by decreasing exclusionary practices, such as the use of seclusion and the Mental Health Act 1983

Ensure that the safety and dignity of service users and the safety of staff are priorities when anticipating or managing violence and aggression.

Use of restrictive interventions must be undertaken in a manner that complies with the Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

Unless a service user is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the Mental Capacity Act 2005, health and social care provider organisations must ensure that the use of restrictive interventions does not impose restrictions that amount to a deprivation of liberty.

Staff Training

In any setting in which restrictive interventions could be used, health and social care provider organisations should train staff to understand and apply the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health Act 1983.

Involving Service Users in Decision-Making

Involve service users in all decisions about their care and treatment, and develop care and risk management plans jointly with them. If a service user is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.

Check whether service users have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them, as soon as possible (for example, during admission to an inpatient psychiatric unit) and take this information into account when making decisions about care.

If a service user has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, during admission to an inpatient psychiatric unit). Ensure that service users understand the main side-effect profiles of the medications recommended in this guideline for rapid tranquillisation (see recommendation below) so that they can make an informed choice.

Ensure that service users understand that during any restrictive intervention their human rights will be respected and the least restrictive intervention will be used to enable them to exercise their rights (for example, their right to follow religious or cultural practices during restrictive interventions) as much as possible. Identify and reduce any barriers to a service user exercising their rights and, if this is not possible, record the reasons in their notes.

Ensure that carers are involved in decision-making whenever possible, if the service user agrees, and that carers are involved in decision-making for all service users who lack mental capacity, in accordance with the Mental Capacity Act 2005.

Preventing Violations of Service Users' Rights

Evaluate, together with the service user, whether adjustments to services are needed to ensure that their rights and those of their carers (including rights related to protected characteristics as defined by the Equality Act 2010) are respected, and make any adjustments that are needed. Adjustments might include providing a particular type of support, modifying the way services are delivered or the approach to interaction with the service user, or making changes to facilities. Record this in the service user's care plan.

Health and social care provider organisations should train staff in cultural awareness and in the organisation's duties under the Equality Act 2010.

Working with the Police

Health and social care provider organisations should work with the police, and local service user groups if possible, to develop policies for joint working and locally agreed operating protocols that cover:

- When and how police enter health or social care settings (including psychiatric and forensic inpatients, emergency departments, general health inpatients, general practitioner [GP] surgeries, social care and community settings and 136 place-of-safety suites)
- When and how health and social care professionals enter police cells
- Transferring service users between settings

Review the operating protocols regularly to ensure compliance with the policies and update the policies in light of operational experience.

Anticipating and Reducing the Risk of Violence and Aggression

Reducing the Use of Restrictive Interventions

Staff Training

Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. This training should enable staff to develop:

- A person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship
- An understanding of the relationship between mental health problems and the risk of violence and aggression
- Skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors
- Skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation)
- Skills, methods and techniques to undertake restrictive interventions safely when these are required
- Skills to undertake an immediate post-incident debrief (see "Using Restrictive Interventions in Inpatient Psychiatric Settings")
- Skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service (see "Using Restrictive Interventions in Inpatient Psychiatric Settings").

Restrictive Intervention Reduction Programme

Health and social care provider organisations should ensure that all services that use restrictive interventions have a restrictive intervention reduction programme (see recommendation below) to reduce the incidence of violence and aggression and the use of restrictive interventions.

Restrictive intervention reduction programmes should:

- Ensure effective service leadership
- Address environmental factors likely to increase or decrease the need for restrictive interventions (see recommendation below)
- Involve and empower service users and their carers
- Include leisure activities that are personally meaningful and physical exercise for service users
- Use clear and simple care pathways
- Use de-escalation
- Use crisis and risk management plans and strategies to reduce the need for restrictive interventions
- Include post-incident debrief and review (see "Using Restrictive Interventions in Inpatient Psychiatric Settings")
- Explore the current and potential use of technology in reporting, monitoring and improving the use of restrictive interventions
- Have routine outcome monitoring, including quality of life and service user experience
- Be based on outcome measures (safety, effectiveness and service user experience) to support quality improvement programmes
- Include regular staff training in line with recommendation above

Health and social care provider organisations should collate, analyse and synthesise all data about violent events and the use of restrictive interventions, and involve service users in the process. The information should:

- Be shared with the teams and services involved
- Be shared with the trust board or equivalent organisational governing body
- Be linked to the standards set in safeguarding procedures

Health and social care provider organisations should develop a service user experience monitoring unit, or equivalent service user group, led by service users and including staff, to report and analyse data on violence and aggression and the use of restrictive interventions.

Health and social care provider organisations should publish board reports on their public Web sites that include data about incidents of violence and aggression and use of restrictive interventions within each team, ward and service, and include reasons for the similarities and differences between services.

A Framework for Anticipating and Reducing Violence and Aggression in Inpatient Psychiatric Wards

Use the following framework to anticipate violence and aggression in inpatient psychiatric wards, exploring each domain to identify ways to reduce violence and aggression and the use of restrictive interventions.

- Ensure that the staff work as a therapeutic team by using a positive and encouraging approach, maintaining staff emotional regulation and self-management (see "Preventing Violence and Aggression") and encouraging good leadership.
- Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties.

- Recognise possible teasing, bullying, unwanted physical or sexual contact, or miscommunication between service users.
- Recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression).
- Anticipate the impact of the regulatory process on each service user, for example, being formally detained, having leave refused, having a failed detention appeal or being in a very restricted environment such as a low-, medium- or high-secure hospital.
- Improve or optimise the physical environment (for example, use unlocked doors whenever possible, enhance the décor, simplify the ward layout and ensure easy access to outside spaces and privacy).
- Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to leave the building) can be a trigger for violence and aggression.
- Anticipate and manage any personal factors occurring outside the hospital (for example, family disputes or financial difficulties) that may affect a service user's behaviour.

Assessing and Managing the Risk of Violence and Aggression

When assessing and managing the risk of violence and aggression use a multidisciplinary approach that reflects the care setting.

Before assessing the risk of violence or aggression:

- Take into account previous violent or aggressive episodes because these are associated with an increased risk of future violence and aggression.
- Do not make negative assumptions based on culture, religion or ethnicity.
- Recognise that unfamiliar cultural practices and customs could be misinterpreted as being aggressive.
- Ensure that the risk assessment will be objective and take into account the degree to which the perceived risk can be verified.

Carry out the risk assessment with the service user and, if they agree, their carer. If this finds that the service user could become violent or aggressive, set out approaches that address:

- Service user-related domains in the framework (see recommendation above)
- Contexts in which violence and aggression tend to occur
- Usual manifestations and factors likely to be associated with the development of violence and aggression
- Primary prevention strategies that focus on improving quality of life and meeting the service user's needs
- Symptoms or feelings that may lead to violence and aggression, such as anxiety, agitation, disappointment, jealousy and anger, and secondary prevention strategies focusing on these symptoms or feelings
- De-escalation techniques that have worked effectively in the past
- Restrictive interventions that have worked effectively in the past, when they are most likely to be necessary and how potential harm or discomfort can be minimised

Consider using an actuarial prediction instrument such as the BVC (Brøset Violence Checklist) or the DASA-IV (Dynamic Appraisal of Situational Aggression – Inpatient Version), rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings.

Consider offering service users with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

Regularly review risk assessments and risk management plans, addressing the service user and environmental domains listed under "A Framework for Anticipating and Reducing Violence and Aggression in Inpatient Psychiatric Wards" and following the recommendations above regarding risk assessment. The regularity of the review should depend on the assessment of the level of risk. Base the care plan on accurate and thorough risk assessments.

If service users are transferring to another agency or care setting, or being discharged, share the content of the risk assessment with staff in the relevant agencies or care settings, and with carers.

An Individualised Pharmacological Strategy to Reduce the Risk of Violence and Aggression

A multidisciplinary team that includes a psychiatrist and a specialist pharmacist should develop and document an individualised pharmacological strategy for using routine and p.r.n. (when needed) medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

The multidisciplinary team should review the pharmacological strategy and the use of medication at least once a week and more frequently if events

are escalating and restrictive interventions are being planned or used. The review should be recorded and include:

- Clarification of target symptoms
- The likely timescale for response to medication
- The total daily dose of medication, prescribed and administered, including p.r.n. medication
- The number of and reason for any missed doses
- Therapeutic response
- The emergence of unwanted effects

If rapid tranquillisation is being used, a senior doctor should review all medication at least once a day.

Preventing Violence and Aggression

Searching

Developing a Policy on Searching

Health and social care provider organisations should have an operational policy on the searching of service users, their belongings and the environment in which they are accommodated, and the searching of carers and visitors. The policy should address:

- The reasons for carrying out a search, ensuring that the decision to search is proportionate to the risks
- The searching of service users detained under the Mental Health Act 1983 who lack mental capacity
- The rationale for repeated searching of service users, carers or visitors, for example those who misuse drugs or alcohol
- The legal grounds for, and the methods used, when undertaking a search without consent, including when the person physically resists searching
- Which staff members are allowed to undertake searching and in which contexts
- Who and what can be searched, including persons, clothing, possessions and environments
- The storage, return and disposal of drugs or alcohol
- How to manage any firearms or other weapons carried by service users, including when to call the police
- Links to other related policies such as those on drugs and alcohol, and on police liaison

Develop and share a clear and easily understandable summary of the policy on searching, for use across the organisation for all service users, carers or visitors who may be searched.

Carrying Out Searches

Health and social care provider organisations should ensure that searches are undertaken by 2 members of staff, at least 1 of whom should be the same sex as the person being searched.

When a decision has been made to undertake a search:

- Provide the person who is to be searched with the summary of the organisation's policy on searching
- Seek consent to undertake the search
- Explain what is being done and why throughout the search
- Ensure the person's dignity and privacy are respected during the search
- Record what was searched, why and how it was searched, and the disposal of any items found

If a service user refuses to be searched, carry out a multidisciplinary review of the need to perform a search using physical force and explore any consequences in advance. Use physical force only as a last resort.

If consent for a search has not been given, a multidisciplinary review has been conducted and physical force has been used, conduct an immediate post-incident debrief and a formal external post-incident review (see "Using Restrictive Interventions in Inpatient Psychiatric Settings") with the service user that includes a visit from an advocacy service or hospital manager.

If a service user is carrying a weapon, ask them to place it in a neutral location rather than handing it over.

If a service user who is at risk of becoming violent or aggressive is in a room or area where there are objects that could be used as weapons, remove the objects or relocate the service user.

Audit the exercise of powers of search and report the outcomes to the trust board or equivalent governing body at least twice a year.

Using p.r.n. Medication

When prescribing p.r.n. medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:

- Do not prescribe p.r.n. medication routinely or automatically on admission.
- Tailor p.r.n. medication to individual need and include discussion with the service user if possible.
- Ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan.
- Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British National Formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquillisation.
- Only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor.
- Ensure that the interval between p.r.n. doses is specified.

The multidisciplinary team should review p.r.n. medication at least once a week and, if p.r.n. medication is to be continued, the rationale for its continuation should be included in the review. If p.r.n. medication has not been used since the last review, consider stopping it.

De-escalation

Staff Training

Health and social care provider organisations should give staff training in de-escalation that enables them to:

- Recognise the early signs of agitation, irritation, anger and aggression
- Understand the likely causes of aggression or violence, both generally and for each service user
- Use techniques for distraction and calming, and ways to encourage relaxation
- Recognise the importance of personal space
- Respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation

General Principles

Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.

Separate agitated service users from others (using quiet areas of the ward, bedrooms, comfort rooms, gardens or other available spaces) to aid de-escalation, ensuring that staff do not become isolated.

Use a wide range of verbal and non-verbal skills and interactional techniques to avoid or manage known 'flashpoint' situations (such as refusing a service user's request, asking them to stop doing something they wish to do or asking that they do something they don't wish to do) without provoking aggression.

Encourage service users to recognise their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to discuss and negotiate their wishes should they become agitated. Include this information in care plans and advance statements and give a copy to the service user.

Communicate respect for and empathy with the service user at all stages of de-escalation.

De-escalation Techniques

If a service user becomes agitated or angry, 1 staff member should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non-confrontational manner.

Use emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, body posture and eye contact) when carrying out de-escalation.

Use a designated area or room to reduce emotional arousal or agitation and support the service user to become calm. In services where seclusion is practised, do not routinely use the seclusion room for this purpose because the service user may perceive this as threatening.

Using Restrictive Interventions in Inpatient Psychiatric Settings

Restrictive interventions are most likely to be used in inpatient psychiatric settings, but may be used in emergency departments, outpatient services

and child and adolescent mental health services (CAMHS).

See "Implementation: getting started" in the original guideline document for information about putting the recommendations on manual restraint, rapid tranquillisation and formal external post-incident reviews into practice.

Staff Training

Health and social care provider organisations should train staff working in inpatient psychiatric settings to undertake restrictive interventions and understand the risks involved in their use, including the side-effect profiles of the medication recommended for rapid tranquillisation in this guideline, and to communicate these risks to service users.

Staffing and Equipment

Health and social care provider organisations should:

- Define staff:patient ratios for each inpatient psychiatric ward and the numbers of staff required to undertake restrictive interventions
- Ensure that restrictive interventions are used only if there are sufficient numbers of trained staff available
- Ensure the safety of staff during the use of restrictive interventions, including techniques to avoid injuries from needles during rapid tranquillisation

Health and social care provider organisations should ensure that resuscitation equipment is immediately available if restrictive interventions might be used and:

- Include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, suction and first-line resuscitation medications
- Maintain equipment and check it every week

Staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used.

Using Restrictive Interventions

Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention.

Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

Ensure that the techniques and methods used to restrict a service user:

- Are proportionate to the risk and potential seriousness of harm
- Are the least restrictive option to meet the need
- Are used for no longer than necessary
- Take account of the service user's preferences, if known and it is possible to do so
- Take account of the service user's physical health, degree of frailty and developmental age

Observation

General Principles

Staff should be aware of the location of all service users for whom they are responsible, but not all service users need to be kept within sight.

At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the service user. As part of the assessment, the nurse should evaluate the impact of the service user's mental state on the risk of violence and aggression, and record any risk in the notes.

Developing a Policy on Observation

Health and social care provider organisations should have a policy on observation and positive engagement that includes:

- Definitions of levels of observation in line with the recommendation below
- Who can instigate, increase, decrease and review observation
- When an observer should be male or female

- How often reviews should take place
- How service users' experience of observation will be taken into account
- How to ensure that observation is underpinned by continuous attempts to engage therapeutically
- The levels of observation necessary during the use of other restrictive interventions (for example, seclusion)
- The need for multidisciplinary review when observation continues for 1 week or more

Levels of Observation

Staff in inpatient psychiatric wards (including general adult wards, older adult wards, psychiatric intensive care units and forensic wards) should use the following definitions for levels of observation, unless a locally agreed policy states otherwise.

- Low-level intermittent observation: the baseline level of observation in a specified psychiatric setting. The frequency of observation is once every 30 to 60 minutes.
- High-level intermittent observation: usually used if a service user is at risk of becoming violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15 to 30 minutes.
- Continuous observation: usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one-to-one nurse, with immediate access to other members of staff if needed.
- Multiprofessional continuous observation: usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

Using Observation

Use observation only after positive engagement with the service user has failed to dissipate the risk of violence and aggression.

Recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.

Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.

Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the service user agrees, tell their carer about the aims and level of observation.

Record decisions about observation levels in the service user's notes and clearly specify the reasons for the observation.

When deciding on levels of observation take into account:

- The service user's current mental state
- Any prescribed and non-prescribed medications and their effects
- The current assessment of risk
- The views of the service user, as far as possible

Record clearly the names and titles of the staff responsible for carrying out a review of observation levels (see recommendation above) and when the review should take place.

Staff undertaking observation should:

- Take an active role in engaging positively with the service user
- Be appropriately briefed about the service user's history, background, specific risk factors and particular needs
- Be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
- Be approachable, listen to the service user and be able to convey to the service user that they are valued

Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours. If observation is needed for longer than 2 hours, ensure the staff member has regular breaks.

When handing over to another staff member during a period of observation, include the service user in any discussions during the handover if possible.

Tell the service user's psychiatrist or on-call doctor as soon as possible if observation above the general level is carried out (see recommendation above).

Manual Restraint

Health and social care provider organisations should ensure that manual restraint is undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead.

When using manual restraint, avoid taking the service user to the floor, but if this becomes necessary:

- Use the supine (face up) position if possible or
- If the prone (face down) position is necessary, use it for as short a time as possible

Do not use manual restraint in a way that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.

Do not use manual restraint in a way that interferes with the service user's ability to communicate, for example by obstructing the eyes, ears or mouth.

Undertake manual restraint with extra care if the service user is physically unwell, disabled, pregnant or obese.

Aim to preserve the service user's dignity and safety as far as possible during manual restraint.

Do not routinely use manual restraint for more than 10 minutes.

Consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes).

Ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable, proportionate to the situation and applied for the shortest time possible.

One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- Able to protect and support the service user's head and neck, if needed
- Able to check that the service user's airway and breathing are not compromised
- Able to monitor vital signs
- Supported throughout the process

Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.

Mechanical Restraint

Health and social care provider organisations should ensure that mechanical restraint in adults is used only in high-secure settings (except when transferring service users between medium- and high-secure settings as in recommendation below) and its use is reported to the trust board.

Use mechanical restraint only as a last resort and for the purpose of:

- Managing extreme violence directed at other people or
- Limiting self-injurious behaviour of extremely high frequency or intensity

Consider mechanical restraint, such as handcuffs, when transferring service users who are at high risk of violence and aggression between medium- and high-secure settings. In this context, restraint should be clearly planned as part of overall risk management.

Rapid Tranquillisation

Rapid tranquillisation in this guideline refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Use either intramuscular lorazepam on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquillisation in adults.

When deciding which medication to use, take into account:

- The service user's preferences or advance statements and decisions
- Pre-existing physical health problems or pregnancy
- Possible intoxication
- Previous response to these medications, including adverse effects

- Potential for interactions with other medications
- The total daily dose of medications prescribed and administered

If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.

If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.

If there is a partial response to intramuscular lorazepam, consider a further dose.

If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine.

If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.

If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this hasn't been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second opinion if needed.

When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed.

After rapid tranquillisation, monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- Appears to be asleep or sedated
- Has taken illicit drugs or alcohol
- Has a pre-existing physical health problem
- Has experienced any harm as a result of any restrictive intervention

Seclusion

Use seclusion in adults only if the service user is detained in accordance with the Mental Health Act 1983. If a service user not detained under the Mental Health Act 1983 is secluded in an emergency, arrange a mental health assessment under the Mental Health Act 1983 immediately.

Services that use seclusion should have a designated seclusion room that:

- Allows staff to clearly observe and communicate with the service user
- Is well insulated and ventilated, with temperature controls outside the room
- Has access to toilet and washing facilities
- Has furniture, windows and doors that can withstand damage

Carrying Out Seclusion

Record the use of seclusion in accordance with the Mental Health Act 1983 Code of Practice.

Ensure that seclusion lasts for the shortest time possible. Review the need for seclusion at least every 2 hours and tell the service user that these reviews will take place.

Set out an observation schedule for service users in seclusion. Allocate a suitably trained member of staff to carry out the observation, which should be within eyesight as a minimum.

Ensure that a service user in seclusion keeps their clothing and, if they wish, any personal items, including those of personal, religious or cultural significance, unless doing so compromises their safety or the safety of others.

Rapid Tranquillisation during Seclusion

If rapid tranquillisation is needed while a service user is secluded, undertake with caution following recommendations above and:

- Be aware of and prepared to address any complications associated with rapid tranquillisation
- Ensure the service user is observed within eyesight by a trained staff member

- Undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect

Post-Incident Debrief and Formal Review

In this guideline an incident is defined as any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

Health and social care provider organisations should ensure that wards have sufficient staff with a mix of skills and seniority levels that enable them to:

- Conduct an immediate post-incident debrief (see recommendations below)
- Monitor and respond to ongoing risks, and contribute to formal external post-incident reviews (see recommendations below)

The trust board or equivalent governing body should ensure that it receives regular reports from each ward about violent incidents, the use of restrictive interventions, service users' experience of those interventions and the learning gained.

Immediate Post-Incident Debrief

After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

Use the framework outlined under "A Framework for Anticipating and Reducing Violence and Aggression in Inpatient Psychiatric Wards" to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

Advise the service user experience monitoring unit, or equivalent service user group, to start a formal external post-incident review.

Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer. Offer the service user the opportunity to write their perspective of the event in the notes.

Ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.

Ensure that all staff involved in the incident have the opportunity to discuss their experience with staff who were not involved.

Discuss the incident with service users, witnesses and staff involved only after they have recovered their composure and aim to:

- Acknowledge the emotional responses to the incident and assess whether there is a need for emotional support for any trauma experienced
- Promote relaxation and feelings of safety
- Support a return to normal patterns of activity
- Ensure that everyone involved in the service user's care, including their carers, has been informed of the event, if the service user agrees

Ensure that the necessary documentation has been completed.

Formal External Post-Incident Review

The service user experience monitoring unit or equivalent service user group should undertake a formal external post-incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post-incident review:

- Is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame
- Uses the information recorded in the immediate post-incident debrief and the service user's notes relating to the incident
- Includes interviews with staff, the service user involved and any witnesses if further information is needed
- Uses the framework under "A Framework for Anticipating and Reducing Violence and Aggression in Inpatient Psychiatric Wards" above to:
    - Evaluate the physical and emotional impact on everyone involved, including witnesses
    - Help service users and staff to identify what led to the incident and what could have been done differently
    - Determine whether alternatives, including less restrictive interventions, were discussed
    - Determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
    - Recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate

- Avoid a similar incident happening in future, if possible

The service user experience monitoring unit or equivalent service user group should give a report to the ward that is based on the formal external post-incident review.

Managing Violence and Aggression in Emergency Departments

For guidance on manual restraint and rapid tranquillisation, which may be used in emergency departments, see recommendations under "Using Restrictive Interventions in Inpatient Psychiatric Settings." Emergency department staff may also be involved in immediate post-incident debriefs (see recommendations in the previous section).

Liaison Mental Health

Healthcare provider organisations and commissioners should ensure that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric nurses who are able to work with children, young people, adults and older adults.

Healthcare provider organisations should ensure that a full mental health assessment is available within 1 hour of alert from the emergency department at all times.

Staff Training

Healthcare provider organisations should train staff in emergency departments in methods and techniques to reduce the risk of violence and aggression, including anticipation, prevention and de-escalation.

Healthcare provider organisations should train staff in emergency departments in mental health triage.

Healthcare provider organisations should train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses).

Staffing

Healthcare provider organisations should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline.

Preventing Violence and Aggression

Undertake mental health triage for all service users on entry to emergency departments, alongside physical health triage.

Healthcare provider organisations should ensure that emergency departments have at least 1 designated interview room for mental health assessment that:

- Is close to or part of the main emergency department receiving area
- Is made available for mental health assessments as a priority
- Can comfortably seat 6 people
- Is fitted with an emergency call system, an outward opening door and a window for observation
- Contains soft furnishings and is well ventilated
- Contains no potential weapons

Staff interviewing a person in the designated interview room should:

- Inform a senior member of the emergency nursing staff before starting the interview
- Make sure another staff member is present

Managing Violence and Aggression

If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with recommendations under "Using Restrictive Interventions in Inpatient Psychiatric Settings," and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

Managing Violence and Aggression in Community and Primary Care Settings

For guidance on manual restraint, which may be used by ambulance staff, see "Using Restrictive Interventions in Inpatient Psychiatric Settings." Ambulance staff may also be involved in immediate post-incident debriefs (see "Using Restrictive Interventions in Inpatient Psychiatric Settings").

Developing Policies

Health and social care provider organisations, including ambulance trusts, should ensure that they have up-to-date policies on the management of violence and aggression in people with mental health problems, and on lone working, in community and primary care settings, in line with this guideline.

Staff Training

Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.

Health and social care provider organisations, including ambulance trusts, should ensure that staff working in community and primary care settings are able to undertake a risk assessment for violence and aggression in collaboration with service users known to be at risk and their carers if possible. The risk assessment should be available for case supervision and in community teams it should be subject to multidisciplinary review.

Managing Violence and Aggression

After a risk assessment has been carried out, staff working in community and primary care settings should:

- Share the risk assessment with other health and social care services and partner agencies (including the police and probation service) who may be involved in the person's care and treatment, and with carers if there are risks to them
- Be aware of professional responsibilities in relation to limits of confidentiality and the need to share information about risks

In community settings, carry out Mental Health Act 1983 assessments with a minimum of 2 people, for example a doctor and a social worker.

Community mental health teams should not use manual restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police.

Managing Violence and Aggression in Children and Young People

Staff Training

Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children and young people. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible. Staff who might undertake restrictive interventions should be trained:

- In the use of these interventions in these age groups
- To adapt the manual restraint techniques for adults in recommendations under "Using Restrictive Interventions in Inpatient Psychiatric Settings," adjusting them according to the child or young person's height, weight and physical strength
- In the use of resuscitation equipment (see "Using Restrictive Interventions in Inpatient Psychiatric Settings") in children and young people

CAMHS should have a clear and consistently enforced policy about managing antisocial behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing the behaviour.

CAMHS staff should be familiar with the Children Act 1989 and 2004 and the Mental Health Act 1983, as well as the Mental Capacity Act 2005 and the Human Rights Act 1998. They should also be aware of the United Nations Convention on the Rights of the Child.

Managing Violence and Aggression

Manage violence and aggression in children and young people in line with the recommendations for adults under "Principles for Managing Violence and Aggression," taking into account:

- The child or young person's level of physical, intellectual, emotional and psychological maturity
- The recommendations for children and young people in this section
- That the Mental Capacity Act 2005 applies to young people aged 16 and over

Collaborate with those who have parental responsibility when managing violence and aggression in children and young people.

Use safeguarding procedures to ensure the child or young person's safety.

Involve the child or young person in making decisions about their care whenever possible.

Assessment and Initial Management

Assess and treat any underlying mental health problems in line with relevant NICE guidelines, including those on antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, psychosis and schizophrenia in children and young people, autism diagnosis in children and young people and autism (see the NGC summaries of the NICE guidelines Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management, Attention deficit hyperactivity disorder. Diagnosis and management of ADHD in children, young people and adults, Psychosis and schizophrenia in children and young people: recognition and management, and Autism. Recognition, referral and diagnosis of children and young people on the autism spectrum).

Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.

Identify cognitive, language, communication and cultural factors that may increase the risk of violence or aggression in a child or young person.

Consider offering children and young people with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

Offer support and age-appropriate interventions (including parent training programmes) in line with the NGC summary of the NICE guideline Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management to parents of children and young people whose behaviour is violent or aggressive.

De-escalation

Use de-escalation in line with recommendations above for adults, modified for children and young people, and:

- Use calming techniques and distraction
- Offer the child or young person the opportunity to move away from the situation in which the violence or aggression is occurring, for example to a quiet room or area
- Aim to build emotional bridges and maintain a therapeutic relationship

Restrictive Interventions

Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent.

When restrictive interventions are used, monitor the child or young person's wellbeing closely and continuously, and ensure their physical and emotional comfort.

Do not use punishments, such as removing contact with parents or carers or access to social interaction, withholding nutrition or fluids, or corporal punishment, to force compliance.

Manual Restraint

If possible, allocate a staff member who is the same sex as the child or young person to carry out manual restraint.

Mechanical Restraint

Do not use mechanical restraint in children.

Healthcare provider organisations should ensure that, except when transferring young people between medium- and high-secure settings (as in the recommendation below), mechanical restraint in young people is used only in high-secure settings (on those occasions when young people are being treated in adult high-secure settings), in accordance with the Mental Health Act 1983 and with support and agreement from a multidisciplinary team that includes a consultant psychiatrist in CAMHS.

Consider using mechanical restraint, such as handcuffs, when transferring young people who are at high risk of violence or aggression between medium and high-secure settings, and remove the restraint at the earliest opportunity.

Rapid Tranquillisation

Use intramuscular lorazepam for rapid tranquillisation in a child or young person and adjust the dose according to their age and weight. (At the time of publication [May 2015], lorazepam did not have a UK marketing authorisation for use in children and young people for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.)

If there is only a partial response to intramuscular lorazepam, check the dose again according to the child or young person's age and weight and consider a further dose.

Monitor physical health and emotional impact continuously when undertaking rapid tranquillisation in a child or young person.

Seclusion

Decisions about whether to seclude a child or young person should be approved by a senior doctor and reviewed by a multidisciplinary team at the earliest opportunity.

Report all uses of seclusion to the trust board or equivalent governing body.

Do not seclude a child in a locked room, including their own bedroom.

Definitions

Strength of Recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group (GDG) makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the GDG is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The GDG usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the GDG uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The GDG uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the GDG is confident that an intervention will not be of benefit for most patients.

Interventions That Could Be Used

The GDG uses 'consider' when confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Clinical Algorithm(s)

A National Institute for Health and Care Excellence (NICE) pathway titled "Violence and Aggression Overview" is available from the NICE Web site.

Scope

Disease/Condition(s)

Violent and physically threatening behaviour

Guideline Category

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Emergency Medicine

Family Practice

Internal Medicine

Nursing

Pediatrics

Preventive Medicine

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Emergency Medical Technicians/Paramedics

Health Care Providers

Hospitals

Nurses

Occupational Therapists

Patients

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Substance Use Disorders Treatment Providers

Guideline Objective(s)

- To improve access and engagement with treatment and services for people with a mental health problem whose behaviour is violent or aggressive
- To evaluate the role of specific psychological, psychosocial and pharmacological interventions in the anticipation, reduction, prevention and treatment of violence and aggression
- To evaluate the role of psychological and psychosocial interventions in combination with pharmacological interventions in the treatment of violence and aggression
- To evaluate the role of specific service-level interventions for people with a mental health problem whose behaviour is violent or aggressive, or there is a risk that it could become violent or aggressive
- To integrate the above to provide best-practice advice on the care of service users throughout the course of their treatment
- To promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service (NHS) in England

Target Population

- Adults (aged 18 and over), children (aged 12 and under) and young people (aged 13 to 17) with a mental health problem who are currently service users within mental health, health and community settings
- Carers of service users with mental health problems in these settings

Note: This guideline does not cover but may be relevant to practice regarding people who do not have mental health problems, those who are not carers of people with mental health problems, people in whom the primary behaviour is self-harm, and people with a primary diagnosis of learning disability.

Interventions and Practices Considered

1. Anticipating and reducing the risk of violence and aggression
    - Reducing the use of restrictive interventions (staff training, restrictive intervention reduction program)
    - Framework to anticipate and reduce violence and aggression in inpatient psychiatric wards
    - Individualised pharmacological strategy to reduce the risk of violence and aggression
2. Preventing violence and aggression
    - Developing a policy on searching
    - Carrying out searches
    - Using p.r.n. (when needed) medication as part of a de-escalation strategy
    - De-escalation staff training, principles, and techniques
3. Using restrictive interventions in inpatient psychiatric settings
    - Staff training
    - Staffing and equipment
    - Using restrictive interventions
    - Developing and using an observation policy
    - Use of manual restraint
    - Use of mechanical restraint
    - Rapid tranquillisation (intramuscular lorazepam on its own or intramuscular haloperidol combined with intramuscular promethazine)
    - Use of seclusion
    - Rapid tranquillisation during seclusion
    - Post-incident debriefing and formal review
4. Managing violence and aggression in emergency departments
    - Ensuring that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric nurses
    - Staff training
    - Staffing
    - Preventing violence and aggression
    - Managing violence and aggression

5. Managing violence and aggression in community and primary care settings
    - Developing policies
    - Staff training
    - Managing violence and aggression
6. Managing violence and aggression in children and young people
    - Staff training using training programs specifically designed for staff working with children and young people
    - Assessment and initial management in line with relevant mental health guidelines
    - De-escalation techniques
    - Use of restrictive interventions
    - Use of manual restraint
    - Avoiding use of mechanical restraint
    - Use of lorazepam for rapid tranquillisation
    - Use of seclusion

Major Outcomes Considered

- Rates of seclusion
- Rates of manual restraint
- Use of antipsychotic drugs
- Use of rapid tranquillisation methods
- Experience of service users and carers
- Rates of injury in service users
- Rates of injury in staff
- Cost effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Clinical Review Methods

The Search Process

Scoping Searches

A broad preliminary search of clinical guidelines, Health Technology Assessment (HTA) reports, key systematic reviews and randomised controlled trials (RCTs) was undertaken in early 2013 to obtain an overview of the issues likely to be covered by the scope, and to help define key areas.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate as much relevant evidence as possible. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to certain study designs if specified in the review protocol, and conducted in the following databases:

- Cochrane Database of Abstracts of Reviews of Effects
- Cochrane Database of Systematic Reviews (CDSR)
- Cochrane Central Register of Controlled Trials (CENTRAL)
- Excerpta Medica Database (EMBASE)
- HTA database (technology assessments)
- Medical Literature Analysis and Retrieval System Online (MEDLINE)/MEDLINE In-Process
- Psychological Information Database (PsycINFO)

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches and discussions of the results of the searches with the review team and Guideline Development Ground (GDG) to ensure that all possible relevant search terms were covered. To assure comprehensive coverage, search terms for the guideline topic were kept purposely broad to help counter dissimilarities in database indexing practices and thesaurus terms, and imprecise reporting of study populations by authors in the titles and abstracts of records. Full details of the search strategies and filters used for the systematic review of clinical evidence are provided in Appendix 10 in the full guideline appendices (see the "Availability of Companion Documents" field).

Reference Management

Citations from each search were downloaded into reference management software and duplicates removed. Records were then screened against the eligibility criteria of the reviews before being appraised for methodological quality. The unfiltered search results were saved and retained for future potential re-analysis to help keep the process both replicable and transparent.

Search Filters

To aid retrieval of relevant and sound studies, filters were used to limit a number of searches to specific study designs. The search filters for systematic reviews and RCTs are adaptations of filters designed by the Health Information Research Unit of McMaster University. The observational and qualitative research filters were developed in-house. Each filter comprises index terms relating to the study type(s) and associated textwords for the methodological description of the design(s).

Date and Language

Systematic database searches were initially conducted in May 2013 up to the most recent searchable date. Search updates were generated on a 6-monthly basis, with the final re-runs carried out in August 2014 ahead of the guideline consultation. After this point, studies were only included if they were judged by the GDG to be exceptional (for example, if the evidence was likely to change a recommendation).

Although no language restrictions were applied at the searching stage, foreign language papers were not requested or reviewed unless they were of particular importance to a review question.

Other Search Methods

Other search methods involved: (a) scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies) for more published reports and citations of unpublished research; (b) asking the GDG; (c) conducting searches in ClinicalTrials.gov for unpublished trial reports; (d) contacting included study authors for unpublished or incomplete datasets.

Study Selection and Assessment of Methodological Quality

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into the study information database. More specific eligibility criteria were developed for each review question and are described in the relevant clinical evidence chapters. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (risk of bias) using a checklist; see The Guidelines Manual (see the "Availability of Companion Documents" field) for templates. The eligibility of each study was confirmed by at least 1 member of the GDG.

Unpublished Evidence

The GDG used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must have been accompanied by a trial report containing sufficient detail to properly assess risk of bias. Second, the evidence must have been submitted with the understanding that

data from the study and a summary of the study's characteristics would be published in the full guideline. Therefore, in most circumstances the GDG did not accept evidence submitted 'in confidence'. However, the GDG recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their research.

Health Economics Methods

The aim of the health economics was to contribute to the guideline's development by providing evidence on the cost effectiveness of interventions for violence and aggression covered in the guideline. This was approached using:

- Systematic literature review of existing economic evidence
- Decision-analytic economic modelling

Systematic reviews of economic literature were conducted in all areas covered in the guideline. Economic modelling was considered in areas with likely major resource implications, where the current extent of uncertainty over cost effectiveness was significant and economic analysis was expected to reduce this uncertainty, in accordance with The Guidelines Manual. Prioritisation of areas for economic modelling was a joint decision between the health economist and the GDG. The rationale for prioritising review questions for economic modelling was set out in an economic plan agreed between NICE, the GDG, the health economist and the other members of the technical team. The cost effectiveness of rapid tranquilisation options was selected as a key issue to be addressed by economic modelling.

Search Strategy for Economic Evidence

Scoping Searches

A broad preliminary search of the literature was undertaken in early 2013 to obtain an overview of the issues likely to be covered by the scope, and help define key areas. Searches were restricted to economic studies and health technology assessment reports, and conducted in the following databases:

- EMBASE
- MEDLINE/MEDLINE In-Process
- HTA database (technology assessments)
- National Health Service Economic Evaluation Database (NHS EED)

Any relevant economic evidence arising from the clinical scoping searches was also made available to the health economist during the same period.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to economic studies and health technology assessment reports, and conducted in the following databases:

- EMBASE
- MEDLINE/MEDLINE In-Process
- PsycINFO
- HTA database (technology assessments)
- NHS EED

Any relevant economic evidence arising from the clinical searches was also made available to the health economist during the same period.

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches, and discussions of the results of the searches with the review team and GDG to ensure that all possible relevant search terms were covered. To assure comprehensive coverage, search terms for violence and aggression were kept purposely broad to help counter dissimilarities in database indexing practices and thesaurus terms, and imprecise reporting of study populations by authors in the titles and abstracts of records.

For standard mainstream bibliographic databases (EMBASE, MEDLINE and PsycINFO) search terms for violence and aggression combined with a search filter for health economic studies. For searches generated in topic-specific databases (HTA, NHS EED) search terms for violence and aggression were used without a filter. The sensitivity of this approach was aimed at minimising the risk of overlooking relevant publications, due to potential weaknesses resulting from more focused search strategies. The search terms are set out in full in Appendix 16 in the full guideline

appendices.

Reference Manager

Citations from each search were downloaded into Reference Manager (a software product for managing references and formatting bibliographies) and duplicates removed. Records were then screened against the inclusion criteria of the reviews Violence and aggression (update) 50 before being quality appraised. The unfiltered search results were saved and retained for future potential re-analysis to help keep the process both replicable and transparent.

Search Filters

The search filter for health economics is an adaptation of a filter designed by the Centre for Reviews and Dissemination. The filter comprises a combination of controlled vocabulary and free-text retrieval methods.

Date and Language Restrictions

Systematic database searches were initially conducted in May 2013 up to the most recent searchable date. Search updates were generated on a 6-monthly basis, with the final re-runs carried out in August 2014. After that point, studies were included only if they were judged by the GDG to be exceptional (for example, the evidence was likely to change a recommendation).

Although no language restrictions were applied at the searching stage, foreign language papers were not requested or reviewed, unless they were of particular importance to an area under review. All the searches were restricted to research published from 2002 onwards in order to obtain data relevant to current healthcare settings and costs.

Other Search Methods

Other search methods involved scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies from the economic and clinical reviews) to identify further studies for consideration.

Full details of the search strategies and filter used for the systematic review of health economic evidence are provided in Appendix 16 in the full guideline appendices.

Inclusion Criteria for Economic Studies

The following inclusion criteria were applied to select studies identified by the economic searches for further consideration:

- Only studies from Organisation for Economic Co-operation and Development countries were included, because the aim of the review was to identify economic information transferable to the UK context.
- Selection criteria based on types of clinical conditions and patients as well as interventions assessed were identical to the clinical literature review.
- Studies were included provided that sufficient details regarding methods and results were available to enable the methodological quality of the study to be assessed, and provided that the study's data and results were extractable. Poster presentations of abstracts were excluded.
- Full economic evaluations that compared 2 or more relevant options and considered both costs and consequences as well as costing analyses that compared only costs between 2 or more interventions were included in the review.
- Studies were included only if the examined interventions were clearly described. This involved the dosage and route of administration, and the duration of treatment in the case of pharmacological therapies; and the types of health professionals involved as well as the frequency and duration of treatment in the case of psychological interventions.

Number of Source Documents

Results of the Systematic Search of Clinical Evidence

The total number of studies considered for each review question and reasons for study exclusion are given in the relevant chapters of the full version of the guideline (see the "Availability of Companion Documents" field).

See Appendix 13 in the full guideline appendices (see the "Availability of Companion Documents" field) for study characteristics tables (update) for included studies.

Results of the Systematic Search of Economic Literature

The titles of all studies identified by the systematic search of the literature were screened for their relevance to the topic (that is, economic issues and information on health-related quality of life associated with violence and aggression). References that were clearly not relevant were excluded first. The abstracts of all potentially relevant studies (27 references) were then assessed against the inclusion criteria for economic evaluations by the health economist. Full texts of the studies potentially meeting the inclusion criteria (including those for which eligibility was not clear from the abstract) were obtained. Studies that did not meet the inclusion criteria, were duplicates, were secondary publications of 1 study, or had been updated in more recent publications were subsequently excluded. Economic evaluations eligible for inclusion (4 references) were then appraised for their applicability and quality using the methodology checklist for economic evaluations. Finally, 1 economic study that partially met the applicability and quality criteria was considered at formulation of the guideline recommendations.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Overall Quality of Outcome Evidence in Grading of Recommendations Assessment, Development and Evaluation (GRADE)

Level	Description
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very Low	Any estimate of effect is very uncertain.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Clinical Review Methods

Data Extraction

Quantitative Analysis

Study characteristics, aspects of methodological quality and outcome data were extracted from all eligible studies using an Excel template.

In most circumstances, for a given outcome (continuous and dichotomous), where more than 50% of the number randomised to any group were missing or incomplete, the study results were excluded from the analysis (except for the outcome 'leaving the study early', in which case the denominator was the number randomised). Where there were limited data for a particular review, the 50% rule was not applied. In these circumstances the evidence was downgraded.

Where possible, outcome data from an intention-to-treat analysis (that is, a 'once-randomised-always-analyse' basis) were used. Where intention-to-treat analysis had not been used or there were missing data, the effect size for dichotomous outcomes were recalculated using best-case and worse-case scenarios. Where conclusions varied between scenarios, the evidence was downgraded (see "Grading the Quality of Evidence" below).

Where some of the studies failed to report standard deviations (for a continuous outcome), and where an estimate of the variance could not be computed from other reported data or obtained from the study author, the following approach was taken. When the number of studies with missing standard deviations was less than one-third and when the total number of studies was at least 10, the pooled standard deviation was imputed (calculated from all the other studies in the same meta-analysis that used the same version of the outcome measure). In this case, the appropriateness of the imputation was assessed by comparing the standardised mean differences (SMDs) of those trials that had reported standard deviations against the hypothetical SMDs of the same trials based on the imputed standard deviations. If they converged, the meta-analytical results were considered to be reliable. When the conditions above could not be met, standard deviations were taken from another related systematic review (if available). In this case, the results were considered to be less reliable.

Consultation with another reviewer or members of the Guideline Development Group (GDG) was used to overcome difficulties with coding. Data extracted by 1 reviewer was checked by a second reviewer. Disagreements were resolved through discussion. Where consensus could not be reached, a third reviewer or GDG members resolved the disagreement. Masked assessment (that is, blind to the journal where the article was published, to the authors, to the institution and to the magnitude of the effect) was not used because it is unclear whether such masking reduces bias.

Evidence Synthesis

The method used to synthesise evidence depended on the review question and availability and type of evidence (see Appendix 6 in the full guideline appendices for full details). Briefly, for questions about test accuracy, bivariate test accuracy meta-analysis was conducted where appropriate. For questions about the effectiveness of interventions, standard meta-analysis was used, otherwise narrative methods were used with clinical advice from the GDG. In the absence of high-quality research, an informal consensus process was used.

Grading the Quality of Evidence

For questions about the effectiveness of interventions, the Grading of Recommendation Assessment, Development and Evaluation (GRADE) approach was used to grade the quality of evidence for each outcome. For questions about the experience of care and risk assessment and prediction, methodology checklists were used to assess the risk of bias, and this information was taken into account when interpreting the evidence. The technical team drafted GRADE evidence profiles using GRADEprofiler (GRADEpro) software (Version 3.6), following advice set out in the GRADE handbook.

Evidence Profiles

A GRADE evidence profile was used to summarise both the quality of the evidence and the results of the evidence synthesis for each 'critical' and 'important' outcome. The GDG made the final decision about the importance of each outcome by informal consensus, and this information was recorded in the review protocol. The GRADE approach is based on a sequential assessment of the quality of evidence, followed by judgment about the balance between desirable and undesirable effects, and subsequent decision about the strength of a recommendation.

Within the GRADE approach to grading the quality of evidence, the following is used as a starting point:

- Randomised controlled trials (RCTs) without important limitations provide high-quality evidence
- observational studies without special strengths or important limitations provide low-quality evidence

For each outcome, quality may be reduced depending on 5 factors: limitations, inconsistency, indirectness, imprecision and publication bias. For the purposes of the guideline, each factor was evaluated using criteria provided in Table 5 in the full version of the guideline.

For observational studies without any reasons for down-grading, the quality may be up-graded if there is a large effect, all plausible confounding would reduce the demonstrated effect (or increase the effect if no effect was observed), or there is evidence of a dose-response gradient (details would be provided under the 'other' column).

Each evidence profile includes a summary of findings: number of participants included in each group, an estimate of the magnitude of the effect, and the overall quality of the evidence for each outcome. Under the GRADE approach, the overall quality for each outcome is categorised into 1 of 4 groups (high, moderate, low, very low) (see the "Rating Scheme for the Strength of the Evidence" field).

Presenting Evidence to the GDG

Study characteristics tables and, where appropriate, forest plots generated with Review Manager Version 5.3 (Cochrane Collaboration, 2014) and GRADE summary of findings table were presented to the GDG.

Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were reported in the study characteristics table and presented to the GDG. The range of effect estimates were included in the GRADE profile, and where appropriate, described narratively.

Summary of Findings Tables

Summary of findings tables generated from GRADEpro were used to summarise the evidence for each outcome and the quality of that evidence (see Table 6 in the full version of the guideline). The tables provide illustrative comparative risks, especially useful when the baseline risk varies for different groups within the population.

Health Economics Methods

Applicability and Quality Criteria for Economic Studies

All economic papers eligible for inclusion were appraised for their applicability and quality using the methodology checklist for economic evaluations recommended by NICE, which is shown in Appendix 17 in the full guideline appendices. All studies that fully or partially met the applicability and quality criteria described in the methodology checklist were considered during the guideline development process. The completed methodology checklists for all economic evaluations considered in the guideline are provided in Appendix 17.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Care Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

The Guideline Development Group (GDG)

During the scope consultation phase, members of the GDG were appointed by an open recruitment process. GDG membership consisted of: professionals in psychiatry, clinical psychology, nursing, social work, general practice and policing; academic experts in psychiatry and psychology; and service users and carers. The guideline development process was supported by staff from the National Collaborating Centre of Mental Health, who undertook the clinical and health economic literature searches, reviewed and presented the evidence to the GDG, managed the process and contributed to drafting the guideline.

GDG Meetings

Thirteen GDG meetings were held between March 22, 2013 and January 20, 2015. During each day-long GDG meeting, in a plenary session, review questions and clinical and economic evidence were reviewed and assessed, and recommendations formulated. At each meeting, all GDG members declared any potential conflicts of interest, and service user and carer concerns were routinely discussed as a standing agenda item.

Service Users and Carers

Individuals with direct experience of services gave an integral service-user focus to the GDG and the guideline. The GDG included 4 service users and carers. They contributed as full GDG members to writing the review questions, providing advice on outcomes most relevant to service users and carers, helping to ensure that the evidence addressed their views and preferences, highlighting sensitive issues and terminology relevant to the guideline, and bringing service user research to the attention of the GDG. In drafting the guideline, they contributed significantly to writing the guideline's introduction and identified recommendations from the service user and carer perspective.

National and International Experts

National and international experts in the area under review were identified through the literature search and through the experience of the GDG

members. These experts were contacted to identify unpublished or soon-to-be published studies, to ensure that up-to-date evidence was included in the development of the guideline. They informed the GDG about completed trials at the pre-publication stage, systematic reviews in the process of being published, studies relating to the cost effectiveness of treatment and trial data if the GDG could be provided with full access to the complete trial report. Appendix 4 of the full version of the guideline lists researchers who were contacted.

Review Protocols

Review questions drafted during the scoping phase were discussed by the GDG at the first few meetings and amended as necessary. The review questions were used as the starting point for developing review protocols for each systematic review. Where appropriate, the review questions were refined once the evidence had been searched and, where necessary, subquestions were generated. The final list of review questions can be found in Appendix 5 of the full version of the guideline (see the "Availability of Companion Documents" field).

For questions about interventions, the PICO (Population, Intervention, Comparison and Outcome) framework was used to structure each question (see Table 1 in the full version of the guideline).

Questions relating to diagnosis or case identification do not involve an intervention designed to treat a particular condition, and therefore the PICO framework was not used. Rather, the questions were designed to pick up key issues specifically relevant to clinical utility, for example their accuracy, reliability, safety and acceptability to the service user.

In some situations, the prognosis of a particular condition is of fundamental importance, over and above its general significance in relation to specific interventions. Areas where this is particularly likely to occur relate to assessment of risk, for example in terms of behaviour modification or screening and early intervention. In addition, review questions related to issues of service delivery are occasionally specified in the remit from the Department of Health. In these cases, appropriate review questions were developed to be clear and concise.

Where review questions about service user experience were specified in the scope, the SPICE (Setting, Perspective, Intervention, Comparison, Evaluation) format was used to structure the questions (see Table 2 in the full version of the guideline).

For each topic, addressed by 1 or more review questions, a review protocol was drafted by the technical team using a standardised template (based on PROSPERO). After a protocol was finalised by the GDG, registration on the PROSPERO Web site was performed for those likely to be published in peer-reviewed journals. All protocols are included in Appendix 9 in the full guideline appendices (see the "Availability of Companion Documents" field).

To help facilitate the literature review, a note was made of the best study design type to answer each question. There are 4 main types of review question of relevance to NICE guidelines. For each type of question, the best primary study design varies, where 'best' is interpreted as 'least likely to give misleading answers to the question'. For questions about the effectiveness of interventions, where randomised controlled trials (RCTs) were not available, the review of other types of evidence was pursued only if there was reason to believe that it would help the GDG to formulate a recommendation.

However, in all cases, a well-conducted systematic review (of the appropriate type of study) is likely to always yield a better answer than a single study.

Linking Evidence to Recommendations

Once the clinical and health economic evidence was summarised, the GDG drafted the recommendations. In making recommendations, the GDG took into account the trade-off between the benefits and harms of the intervention/instrument, as well as other important factors, such as economic considerations, values of the GDG and society, the requirements to prevent discrimination and to promote equality, and the GDG's awareness of practical issues.

Finally, to show clearly how the GDG moved from the evidence to the recommendations, each chapter has a section called 'From evidence to recommendations'. Underpinning this section is the concept of the 'strength' of a recommendation. Some recommendations can be made with more certainty than others. The GDG makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the GDG is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully-informed decision.

Method Used to Answer a Review Question in the Absence of Appropriately Designed, High-Quality Research

In the absence of appropriately designed, high-quality research (including indirect evidence where it would be appropriate to use extrapolation), an informal consensus process was adopted.

The process involved a group discussion of what is known about the issues. The views of GDG were synthesised narratively by a member of the review team, and circulated after the meeting. Feedback was used to revise the text, which was then included in the appropriate evidence review chapter and summarised in the 'linking evidence to recommendations' sections.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group (GDG) makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the GDG is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

Interventions That Must (or Must Not) Be Used

The GDG usually uses 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally the GDG uses 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions That Should (or Should Not) Be Used – a 'Strong' Recommendation

The GDG uses 'offer' (and similar words such as 'refer' or 'advise') when confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. Similar forms of words (for example, 'Do not offer…') are used when the GDG is confident that an intervention will not be of benefit for most patients.

Interventions That Could Be Used

The GDG uses 'consider' when confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Cost Analysis

Presentation of Economic Evidence

The economic evidence considered in the guideline is provided in the respective evidence chapters, following presentation of the relevant clinical evidence in the full version of the guideline (see the "Availability of Companion Documents" field). The references to included studies and the respective evidence tables with the study characteristics and results are provided in Appendix 18 in the full guideline appendices (see the "Availability of Companion Documents"). Characteristics and results of all economic studies considered during the guideline development process are summarised in economic evidence profiles accompanying respective Grading of Recommendation Assessment, Development and Evaluation (GRADE) clinical evidence profiles in Appendix 19.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Stakeholder Contributions

Professionals, service users and companies have contributed to and commented on the guideline at key stages in its development. Stakeholders for

this guideline include:

- Service user and carer stakeholders: national service user and carer organisations that represent the interests of people whose care will be covered by the guideline
- Local service user and carer organisations: but only if there is no relevant national organisation
- Professional stakeholders' national organisations: that represent the healthcare professionals who provide the services described in the guideline
- Commercial stakeholders: companies that manufacture drugs or devices used in treatment of the condition covered by the guideline and whose interests may be significantly affected by the guideline
- Providers and commissioners of health services in England
- Statutory organisations: including the Department of Health
- Government, National Health Service (NHS) Quality Improvement Scotland, the Care Quality Commission and the National Patient Safety Agency
- Research organisations: that have carried out nationally recognised research in the area.

The National Institute for Health and Care Excellence (NICE) clinical guidelines are produced for the NHS in England, so a 'national' organisation is defined as one that represents England or has a commercial interest in England. Stakeholders have been involved in the guideline's development at the following points:

- Commenting on the initial scope of the guideline and attending a scoping workshop held by NICE
- Contributing possible review questions and lists of evidence to the Guideline Development Group (GDG)
- Commenting on the draft of the guideline

Validation of the Guideline

Registered stakeholders had an opportunity to comment on the draft guideline, which was posted on the NICE Web site during the consultation period. Following the consultation, all comments from stakeholders and experts (see Appendix 3a in the full guideline appendices [see the "Availability of Companion Documents" field]) were responded to and the guideline updated as appropriate. NICE also reviewed the guideline and checked that stakeholders' comments had been addressed.

Following the consultation period, the GDG finalised the recommendations and the National Collaborating Centre for Mental Health produced the final documents. These were then submitted to NICE for a quality assurance check. Any errors were corrected by the National Collaborating Centre for Mental Health, then the guideline was formally approved by NICE and issued as guidance to the NHS in England.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is not specifically stated for each recommendation.

The type and quality of evidence supporting each review question are described in evidence profiles in the full version of the guideline (see the "Availability of Companion Documents" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Prevention and appropriate short-term management of violence and aggression in mental health, health, and community settings

Refer to the "Trade-off between clinical benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for benefits of specific interventions and practices.

Potential Harms

- False negative or false positive results of prediction tools
- Side effects of medications
- Risks involved in restrictive interventions
- Adverse effects of rapid tranquillisation

Refer to the "Trade-off between clinical benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for further discussion of harms of specific interventions and practices.

Qualifying Statements

Qualifying Statements

- This guidance represents the view of National Institute for Health and Care Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.
- The guideline assumes that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual service users.
- This guideline recommends some medicines for indications for which they do not have a UK marketing authorisation at the date of consultation, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The service user (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. Where recommendations have been made for the use of medicines outside their licensed indications ('off-label use'), these medicines are marked with a footnote in the recommendations.
- See the "Person-centred care" section in the original guideline document for information about individual needs and preferences and transition of care.
- See the original guideline document for information about safeguarding children.

Implementation of the Guideline

Description of Implementation Strategy

Key Priorities for Implementation

The following recommendations have been identified as priorities for implementation.

See "Implementation: getting started" in the original guideline document for information about putting the recommendations on manual restraint, rapid tranquillisation and formal external post-incident reviews into practice.

Anticipating and Reducing the Risk of Violence and Aggression

Reducing the Use of Restrictive Interventions

Staff Training

Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. This training should enable staff to develop:

- A person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship
- An understanding of the relationship between mental health problems and the risk of violence and aggression
- Skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors
- Skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation)
- Skills, methods and techniques to undertake restrictive interventions safely when these are required
- Skills to undertake an immediate post-incident debrief
- Skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service

A Framework for Anticipating and Reducing Violence and Aggression in Inpatient Psychiatric Wards

Use the following framework to anticipate violence and aggression in inpatient psychiatric wards, exploring each domain to identify ways to reduce violence and aggression and the use of restrictive interventions.

- Ensure that the staff work as a therapeutic team by using a positive and encouraging approach, maintaining staff emotional regulation and self-management and encouraging good leadership.
- Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties.
- Recognise possible teasing, bullying, unwanted physical or sexual contact or miscommunication between service users.
- Recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression).
- Anticipate the impact of the regulatory process on each service user (for example, being formally detained, having leave refused, having a failed detention appeal or being in a very restricted environment such as a low-, medium- or high-secure hospital).
- Improve or optimise the physical environment (for example, use unlocked doors whenever possible, enhance the décor, simplify the ward layout and ensure easy access to outside spaces and privacy).
- Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to leave the building) can be a trigger for violence and aggression.
- Anticipate and manage any personal factors occurring outside the hospital (for example, family disputes or financial difficulties) that may affect a service user's behaviour.

Preventing Violence and Aggression

Using p.r.n. Medication

When prescribing p.r.n. (when needed) medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:

- Do not prescribe p.r.n. medication routinely or automatically on admission.
- Tailor p.r.n. medication to individual need and include discussion with the service user if possible.
- Ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan.
- Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British National Formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquillisation.
- Only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented and carried out under the direction of a senior doctor.
- Ensure that the interval between p.r.n. doses is specified.

De-escalation

Staff Training

Health and social care provider organisations should give staff training in de-escalation that enables them to:

- Recognise the early signs of agitation, irritation, anger and aggression
- Understand the likely causes of aggression or violence, both generally and for each service user

- Use techniques for distraction and calming, and ways to encourage relaxation
- Recognise the importance of personal space
- Respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation

General Principles

Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.

Using Restrictive Interventions in Inpatient Psychiatric Settings

Using Restrictive Interventions

Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

Rapid Tranquillisation

If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.

Post-Incident Debrief and Review

Formal External Post-Incident Review

The service user experience monitoring unit or equivalent service user group should undertake a formal external post-incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post-incident review:

- Is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame
- Uses the information recorded in the immediate post-incident debrief and the service user's notes relating to the incident
- Includes interviews with staff, the service user involved and any witnesses if further information is needed
- Uses the recommended framework to:
    - Evaluate the physical and emotional impact on everyone involved, including witnesses
    - Help service users and staff to identify what led to the incident and what could have been done differently
    - Determine whether alternatives, including less restrictive interventions, were discussed
    - Determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
    - Recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate
    - Avoid a similar incident happening in future, if possible.

Managing Violence and Aggression in Emergency Departments

If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with recommendations under "Using Restrictive Interventions in Inpatient Psychiatric Settings," and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

Managing Violence and Aggression in Community and Primary Care Settings

Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.

Managing Violence and Aggression in Children and Young People

Staff Training

Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children and young people. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible. Staff who might undertake restrictive interventions should be trained:

- In the use of these interventions in these age groups
- To adapt the manual restraint techniques for adults in recommendations, adjusting them according to the child or young person's height, weight and physical strength
- In the use of resuscitation equipment (see recommendation) in children and young people

Managing Violence and Aggression

Manage violence and aggression in children and young people in line with the recommendations for adults, taking into account:

- The child or young person's level of physical, intellectual, emotional and psychological maturity
- The recommendations for children and young people in this section
- That the Mental Capacity Act 2005 applies to young people aged 16 and over

Assessment and Initial Management

Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.

Implementation Tools

Clinical Algorithm

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Violence and aggression: short-term management in mental health, health and community settings. London (UK): National Institute for Health and Care Excellence (NICE); 2015 May 29. 64 p. (NICE guideline; no. 10).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2005 Feb (revised 2015 May 29)

Guideline Developer(s)

National Collaborating Centre for Mental Health - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Care Excellence (NICE)

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

All Guideline Development Group (GDG) members made formal declarations of interest at the outset that were updated at every GDG meeting. The GDG met a total of 13 times throughout the process of guideline development.

See Section 4.4 in the original guideline document for details regarding declarations.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: National Collaborating Centre for Nursing and Supportive Care. Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. London (UK): National Institute for Clinical Excellence (NICE); 2005 Feb. 292 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Available from the National Institute for Health and Care Excellence (NICE) Web site . Also available for download in eBook and ePub formats from the NICE Web site .

Availability of Companion Documents

The following are available:

- Violence and aggression: short-term management in mental health, health and community settings. Full guideline. London (UK): National Institute for Health and Care Excellence (NICE); 2015 May. 253 p. (NICE guideline; no 10). Electronic copies: Available from the National Institute for Health and Care Excellence (NICE) Web site .
- Violence and aggression: short-term management in mental health, health and community settings. Appendices. London (UK): National Institute for Health and Care Excellence (NICE); 2015 May. (NICE guideline; no 10). Electronic copies: Available from the NICE Web site .
- Violence and aggression: short-term management in mental health, health and community settings. Baseline assessment tool. London (UK): National Institute for Health and Care Excellence (NICE); 2015 May. (NICE guideline; no 10). Electronic copies: Available from the NICE Web site .
- Violence and aggression: short-term management in mental health, health and community settings. Costing statement. London (UK): National Institute for Health and Care Excellence (NICE); 2015 May. 10 p. (NICE guideline; no 10). Electronic copies: Available from the NICE Web site .
- The guidelines manual 2012. London (UK): National Institute for Health and Care Excellence (NICE); 2012 Nov. Electronic copies: Available from the NICE Web site .

Patient Resources

The following is available:

- Violence and aggression: short-term management in mental health, health and community settings. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2015 May. 13 p. Electronic copies: Available from the National Institute for Health and Care Excellence (NICE) Web site . Also available for download in eBook and ePub formats from the NICE Web site . Also available in Welsh from the NICE Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI on April 29, 2005. The information was verified by the guideline developer on May 11, 2005. This summary was updated by ECRI Institute on October 2, 2007, following the U.S. Food and Drug Administration (FDA) advisory on Haloperidol. This summary was updated by ECRI Institute on September 30, 2009, following the U.S. Food and Drug Administration advisory on Phenergan (promethazine hydrochloride). This summary was updated by ECRI Institute on March 18, 2010, following the U.S. Food and Drug Administration advisory on Zyprexa (olanzapine). This summary was updated by ECRI Institute on July 30, 2015.

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